DEPARTMENT OF LABOR
DIVISION OF PAID LEAVE
HEALTHY DELAWARE FAMILIES ACT

Statutory Authority: Delaware Code, Section (19 **Del.C.** §105)
19 DE Admin. Code

PROPOSED

PUBLIC NOTICE

Rules Defining and Regulating the Healthy Delaware Families Act and the Division of Paid Leave

In compliance with the State's Administrative Procedures Act (Title 29, Chapter 101 of the Delaware Code) and under the authority of **19 Del.C. §105**, the Delaware Department of Labor ("Department") proposes to introduce regulations concerning the establishment of the Healthy Delaware Families Act ("Act") and to set forth definitions, guidance, procedures, and standards for the implementation of the Act and its Family and Medical Leave Insurance Program ("Program"). The Division of Paid Leave ("Division"), a separate division within the Department, is established and will administer the Act, Program, and these regulations.

In accordance with **29 Del.C. §10116**, persons wishing to submit written comments, suggestions, briefs, and compilations of data or other written materials concerning the proposed regulations should direct them to the following address:

Christopher Counihan
Division Director, Division of Paid Leave
Delaware Department of Labor
4425 North Market Street, 4th Floor
Wilmington, DE 19802

Comments may also be directed via electronic may be directed to PFML@Delaware.gov. Any written submission in response to this notice and relevant to the proposed regulations must be received by the above contact at the Delaware Department of Labor no later than 4:00 p.m. EST,

The action concerning determination of whether to adopt the proposed regulations will be based upon consideration of the written comments and any other written materials filed by the public.

Background

The Department is authorized by the General Assembly of the State of Delaware, to establish rules and

regulations for the administration of the Healthy Delaware Families Act ("Act"). Administering this Act is accomplished with the establishment of the Family and Medical Leave Insurance Program ("Program") and the Family and Medical Leave Insurance Appeal Board ("Board"). The Department is further authorized to adopt and promulgate rules and regulations not inconsistent with Title 19 or of any other law of the State; provided, however that no such rule or regulation shall extend, modify, or conflict with any law of this State or the reasonable implications thereof; and provided further, however, that such rules and regulations, as established by the Department, shall focus primarily on the Act, Program, and Board.

Summary of Proposal

In June 2022, three-fifths of all members elected to each house of the Delaware General Assembly passed Senate Substitute No. 2 for Senate Bill No. 1 as amended by House Amendment No. 1. This bill, known as the "Healthy Delaware Families Act" ("Act"), established the Family and Medical Leave Insurance Program ("Program") and the Family and Medical Leave Insurance Appeal Board ("Board") in the State of Delaware. The Governor signed the bill in July 2022, and it became effective July 1, 2022. Bill Detail - Delaware General Assembly

The Act creates a statewide paid family and medical leave insurance program. Delaware-based employees can access up to 12 weeks of paid family and medical leave through the State's paid leave trust fund for a qualifying event, including for the following: (1) To address a worker's own serious health condition; (2) To care for a family member with a serious health condition; (3) To bond and care for a new child; and (4) To address impact(s) arising from a family member's military deployment.

The first substitute to Senate Bill No. 1 differed with regard to the eligibility determination process, covered relationships, length of leave, forms of leave covered, cumulative leave, eligibility criteria, implementation timeline, appeal process, departmental powers, and not requiring participation from certain smaller businesses. The second substitute to Senate Bill No. 1 differed by making technical corrections, ~~clarifying~~ intent and providing greater statutory detail with regard to appeals, coordination of benefits, definitions, private plans, and departmental powers, and providing temporary flexibility regarding implementation.

Overall, the proposed Rules implement the Act, Program and Board by providing definitions, guidance, processes, and standards for Employees, Covered Individuals, Employers, and Small Businesses, as

defined in the Act. The proposed rules outline procedures, forms, and eligibility standards for Employees who apply to their Employer for claims and benefits payments under the Program and seek review from the Department, including an appeal of a denial to the Board. In addition, the proposed rules also set forth guidance, procedures, and forms for Employers and Small Businesses, as defined in the Act, for their administration of the Act and Program.

Statutory Authority **19 Del.C. §105**.

19 Del.C. §105 **enables the Delaware Department of Labor to adopt and promulgate rules and regulations not inconsistent with Title 19 of the Delaware Code; provided, that no such rule or regulation shall extend, modify, or conflict with any law of the State of Delaware or the reasonable implications thereof.**

Rules Defining and Regulating the Healthy Delaware Families Act and the Division of Paid Leave

1.0 Definitions

For purposes of the Act and the following regulations,

1.1 "**Administrative costs**" means those reasonable costs incurred and necessary for the Division to perform any of the functions under the Act or these regulations.

1.2 "**Application year**" means the 12-month period as defined in the Family and Medical Leave Act, 29 U.S.C. Chapter 28. At the time at which these regulations are written, the Family and Medical Leave Act defines the 12-month period is measured as one of the following ways:

1.2.1 "calendar year": 12-month period that runs from January 1 through December 31;

1.2.2 "any fixed 12-months": 12-month period such as a fiscal year, a year starting on an employee's anniversary date, or a 12-month period required by state law;

1.2.3 "12-month period measured forward": 12-month period measured forward from the first date an employee takes family and medical leave. The next 12-month period would begin the first time family and medical leave is taken after completion of the prior 12-month period; or

1.2.4 "A 'rolling' 12-month period measured backward": 12-month period measured backward from the date an employee uses any family and medical leave. Under the

"rolling" 12-month period, each time an employee takes family and medical leave, the remaining leave entitlement would be the balance of the 12 weeks which has not been used during the immediately preceding 12 months.

1.3 "**Child**" means "son or daughter" as defined in the Family and Medical Leave Act. At the time at which these regulations are written, a "son or daughter" is defined to include a biological, adopted, or foster child, a stepchild, a legal ward, or a child of person standing *in loco parentis* who is either:

1.3.1 Under 18 years of age; or

1.3.2 18 years of age or older and incapable of self-care because of a mental or physical disability at the time that leave under the Family and Medical Leave Act is to commence.

1.3.3 The Family and Medical Leave Act defines "*in loco parentis"* to include those with day-to-day responsibilities to care for and financially support a child. Examples of "*in loco parentis*" include but are not limited to:

1.3.3.1 a grandfather may take leave to care for a grandchild whom he has assumed ongoing responsibility for raising if the child has a serious health condition;

1.3.3.2 an aunt who assumes responsibility for caring for a child after the death of the child's parents may take leave to care for the child if the child has a serious health condition; or

1.3.3.3 a person who will co-parent a same-sex partner's biological child may take leave for the birth of the child and for bonding.

1.3.3.4 an Employee should provide sufficient information to make Employer aware of the *in loco parentis* relationship. Examples of sufficient information may include but not be limited to a simple statement asserting the relationship, including the name of the child and a statement of the Employee's *in loco parentis* relationship to the child.

1.4 "**Covered individual**" as defined in the Act includes an individual employed for at least 1,250 hours of service performed within the territory of the State of Delaware with the Employer during the previous 12-month period. For purposes of determining the service hours requirement, legal standards established under the Family and Medical Leave Act apply. At the time at which these regulations are written, the legal standards under the Family and Medical Leave Act are "those

hours actually worked for the Employer." Paid leave and unpaid leave, including vacation, holidays, furlough, sick leave, leave under the Family and Medical Leave Act, or other time off are not included.

1.5 "**Employee**" means an individual employed by an employer. For purposes of Chapter 37, Title 19 of the Delaware Code, individuals primarily reporting for work at a worksite in this State are employees unless otherwise excluded. Individuals primarily reporting for work at a worksite outside of this State are not considered employees under Chapter 37 unless the employer elects to classify them as such. Employers may reclassify an employee as primarily reporting for work at a worksite in another state for the purposes of Chapter 37 through the duration of that individual's tenure at the out-of-state worksite. An Employer may reclassify an employee primarily reporting for work at a worksite in this State, provided an Employee works at least 60% of their work hours at one worksite in Delaware.

The determination of whether an Employee's particular work hours or wages were earned in Delaware or outside of Delaware shall be determined according to whether the income that arose from those hours and/or wages was withheld from the Employee's paycheck as in-state or out-of-state by the Delaware Department of Finance's rules or regulations.

1.5.1 An "Employee" does not include an individual:

1.5.1.1 covered under 5903(17)a., Title 29, which refers to certain state government employment positions that are considered to be in 'classified service" or "state service". At the time at which these regulations are written, Section 5903(17)a. specifies those individuals as:

1.5.1.1.a Casual seasonal employees may be employed by the State on a temporary basis in order to assist agencies in the following situations:

1.5.1.1.b Casual assistance: employee is needed on a sporadic or on-call basis where hours cannot be predetermined and vary greatly from week to week. Such employees may be used as needed.

1.5.1.1.c Seasonal assistance: employee is needed for peak operating seasons not to exceed 9 months.

1.5.1.1.d Institutional assistance: employee is needed to provide optimum staffing levels for clients or to maintain security in an institution. Such employees may be used as needed.

1.5.1.1.e Part-time assistance: employee works less than 30 hours per week on a consistent basis. Such employees may be used as needed.

1.5.1.1.f Project assistance: employee performs duties related to a specific project that has defined objectives and an established time period of completion that does not exceed 1 year.

1.5.1.1.g Primary incumbent replacement: employee is needed to fulfill the job responsibilities of the primary incumbent who is unable to perform such responsibilities for an extended period of time. Such employees may be used for a maximum of 9 months or the length of time the incumbent is unable to perform the job responsibility, whichever is less.

1.5.1.1.h Intern: employee is a college student enrolled in an academic program and working to gain job related experience. Such employees may be used for a maximum of 9 months.

1.5.1.1.i Co-op student: employee is a high school or college student enrolled in an academic program who is working to gain job related experience. Such employees may work part time during the school year and full time during times when school is not in session and may be used as needed.

1.5.1.1.j Summer/School break assistance: employee is hired for a specific time period and uses this employment as an introduction to government and its services. Such employees may be used for a maximum of 9 months.

1.5.1.2 employed by entities in Title 14 in a position that would be covered under 5903(17)a. of Title 29. Title 14 concerns the Delaware Department of Education and includes those entities that are subject to Title 14 or department; or

1.5.1.3 in an equivalent position with an entity covered by State employee benefits.

1.6 "**Employer**" means…

1.6.1 "**Integrated employer**" means those certain employers that meet the integrated employer test as defined in the Family Medical Leave Act. At the time of writing this regulation, the FMLA defined an "integrated employer" as those separate entities deemed to be part of a single employer for purposes of FMLA and based upon the entire relationship viewed in its totality. Factors considered in determining an integrated employer include: 1) common management; 2) interrelation between operations; 3) centralized control of labor relations; and 4) degree of common ownership/financial control.

1.6.2 "**Successor employer**" means those employers as defined under federal law. At the time of writing this regulation, federal law defines this phrase as a new employer that continues its predecessor's business in substantially unchanged form and hires employees of the predecessor as a majority of its workforce

1.6.3 "Joint employer" means that a relationship exists between an employee and 2 or 5 more employers each of whom can do all of the following:

- Hire and fire the employee.

- Supervise and control the employee's work schedules or conditions of employment.
- Determine the rate and method of payment to the employee.
- Maintain employment records of the employee.

In common usage, a joint employer is a participant in a "contract employee" or "employee leasing" arrangement. For the purposes of the Paid Family Medical Leave insurance program, the concept of the joint employer does not apply. For the purposes of administering the plan, all the duties set forth in the Act and these regulations must be performed by the Employer of Record, which is the entity that hired the employee and which is solely responsible for the payment of any and all payroll taxes (including the payroll contributions under this Act) of that employee.

1.7 "**Equivalent position**" means as is defined under the FMLA. At the time these regulations were written, the FMLA defines this term as a position that is virtually identical to the employee's former position in terms of pay, benefits and working conditions, including privileges, prerequisites, and status. It must involve the same or substantially similar duties and responsibilities, which must entail substantially equivalent skill, effort, responsibility, and authority. (with the subsections below renumbered as appropriate)

1.6 "**Family and Medical Leave Act**" means the Family and Medical Leave Act of 1993 or "FMLA".

1.7 "**Family caregiving**" means those acts as set forth in Section 3702(a) of the Act.

1.8 "**Health care provider**" means as defined under the FMLA. At the time at which these regulations are written, FMLA defines "Health care provider" as:

1.8.1 A doctor of medicine or osteopathy who is authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices; or

1.8.2 Any other person determined by the State to be capable of providing health care services.

1.8.3 Others "capable of providing health care services" include only:

1.8.3.1 Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice in the State and performing within the scope of their practice as defined under State law;

1.8.3.2 Nurse practitioners, nurse-midwives, clinical social workers and physician assistants who are authorized to practice under State law and who are performing within the scope of their practice as defined under State law;

1.8.3.3 Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts. Where an employee or family member is receiving treatment from a Christian Science practitioner, an employee may not object to any requirement from an employer that the employee or family member submit to examination (though not treatment) to obtain a second or third certification from a health care provider other than a Christian Science practitioner except as otherwise provided under applicable State or local law or collective bargaining agreement.

1.8.3.4 Any health care provider from whom an employer or the employer's group health plan's benefits manager will accept certification of the existence of a serious health condition to substantiate a claim for benefits; and

1.8.3.5 A health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of his or her practice as defined under such law.

1.8.4 The phrase "authorized to practice in the State" as used in this section means that the provider must be authorized to diagnose and treat physical or mental health conditions.

1.9 **"In loco parentis"** means as defined under the Family and Medical Leave Act. At the time at which these regulations are written, the FMLA defines "*in loco parentis"* to include those with day-to-day responsibilities to care for and financially support a child.

1.10 **"Line(s) of Coverage"** as defined in these regulations mean the different coverages for the four different types of Leave that are authorized under the Act:

1.9.1 Parental Leave – Leave authorized under Section 3702(a)(1), which offers eligible employees time off in the event of the birth, adoption, or fostering of a child.

1.9.2 Family Caregiver Leave – Leave authorized under Section 3702(a)(2), which offers eligible employees time off in the event of a serious health condition (illness or accident) of a child, spouse, or parent.

1.9.3 Medical Leave - Leave authorized under Sect. 3702(a)(3), which offers eligible employees time off in the event of a serious health condition (illness or accident) of the employee themselves.

1.9.4 Qualified Exigencies - Leave authorized under Sect. 3702(a)(4), which offers eligible employees time off for qualified issues that arise in connection with a military deployment.

Qualified Exigencies is a separate line of coverage, in that it has its own FMLA rules and regulations, but the Act requires that it and Family Caregiver Leave be combined in terms of Eligibility and Contributions. The Act combines both Qualified Exigencies and Family Caregiver Leave into a single Contribution Rate, so the two coverages must be taken together.

1.11 "Parent" as defined under the FMLA. At the time at which these regulations are written, FMLA defines a parent as the biological, adoptive, step, or foster father or mother or any other individual who stood *in loco parentis* to the employee when the employee was a son or daughter as defined by FMLA. This term does not include parents "in law."

1.12 “**Qualifying exigency**” means as defined under the FMLA. At the time at which these regulations are written, FMLA defines a “qualifying exigency” as:

1.11.1 Issues arising from the military member’s short notice deployment (i.e., deployment within seven or less days of notice). For a period of up to seven days from the day the military member receives notice of deployment, an employee may take qualifying exigency leave to address any issue that arises from the short-notice deployment;

1.11.2 Attending military events and related activities, such as official ceremonies, programs, events and informational briefings, or family support or assistance programs sponsored by the military, military service organizations, or the American Red Cross that are related to the member’s deployment.

1.11.3 Certain childcare and related activities arising from the military member’s covered active duty, including arranging for alternative childcare, providing childcare on a non-routine, urgent, immediate need basis, enrolling in or transferring a child to a new school or day care facility. Note: The employee taking FMLA qualifying exigency leave does not need to be related to the military member’s child. However, (1) the military member must be the parent, spouse, son, or daughter of the employee taking FMLA leave, and (2) the child must be the child of the military member (including a child to whom the military member stands in loco parentis).

1.11.4 Certain activities arising from the military member’s covered active duty related to care of the military member’s parent who is incapable of self-care, such as arranging for alternative care, providing care on a non-routine, urgent, immediate need basis, admitting or transferring a parent to a new care facility, and attending certain meetings with staff at a care facility, such as meetings with hospice or social service providers.

Note: The employee taking FMLA qualifying exigency leave does not need to be related to the military member’s parent. However, (1) the military member must be the parent, spouse, son, or daughter of the employee taking FMLA leave, and (2) the parent must be the parent of the military member (including an individual who stood in loco parentis to the military member when the member was a child).

1.11.5 Making or updating financial and legal arrangements to address a military member's absence while on covered active duty, including preparing and executing financial and healthcare powers of attorney, enrolling in the Defense Enrollment Eligibility Reporting System or obtaining military identification cards.

1.11.6 Attending counseling for the employee, the military member, or the child of the military member when the need for that counseling arises from the covered active duty of the military member and is provided by someone other than a health care provider.

1.11.7 Taking up to 15 calendar days of leave to spend time with a military member who is on short-term, temporary Rest and Recuperation leave during deployment. The employee's leave for this reason must be taken while the military member is on Rest and Recuperation leave.

1.11.8 Certain post-deployment activities within 90 days of the end of the military member's covered active duty, including attending arrival ceremonies, reintegration briefings and events, and other official ceremonies or programs sponsored by the military, and addressing issues arising from the death of a military member, including attending the funeral.

1.11.9 Any other event that the Employee and Employer agree is a qualifying exigency.

1.13 "**Prior notice**" means an Employee providing the Employer at least 30 days advance notice before FMLA. FMLA leave is to begin if the need for the leave is foreseeable. If 30 days' notice is not practicable, such as because of a lack of knowledge of approximately when leave will be required to begin, a change in circumstances, or a medical emergency, notice must be given as soon as practicable. "As soon as practicable" means as soon as both possible and practical, considering all the facts and circumstances in the individual case. When an Employee becomes aware of a need for FMLA leave less than 30 days in advance, it should be practicable for the Employee to provide notice of the need for leave either the same day or the next business day. In all cases, however, the determination of when an employee could practicably provide notice must consider the individual facts and circumstances.

1.14 "**Serious health condition**" means as defined under the FMLA. At the time at which these regulations are written, the FMLA defines "serious health condition" as:

an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider as defined under the FMLA. Conditions for cosmetic treatments are administered (such as most treatments for acne or plastic surgery) are not serious health conditions unless inpatient hospital care is required or unless complications develop. Restorative dental or plastic surgery after an injury or removal of cancerous growths are serious health conditions provided all the other conditions of the FMLA regulation are met. Mental illness or allergies may be serious health conditions but only if all the conditions of Section 825.113, Title 29, Code of Federal Regulations are met.

1.15 "Sibling" shall mean the employee's brother or sister by birth or adoption, regardless of gender or marital status; SB1 does not mention the terms "siblings", "sister" or "brother". At the time at which these regulations are written, FMLA does not extend Family Caregiver Leave to employees who request Leave to care for a sick or injured sibling. In certain circumstances where the employee is acting *in loco parentis* to the sibling, the U.S. Department of Labor has allowed for such extensions of Family Caregiver Leave. However, Federal Courts have ruled against these extensions. Since SB1 is silent on this issue and since the extension of Family Caregiver Leave to include coverage for ill or injured siblings would likely result in an increase in total claims for the program sufficient to require an increase in the payroll contribution rate for Family Caregiver coverage, the Department has determined that siblings will not be included in the class of those for whose care employees can be granted Family Caregiver Leave.

1.15 "**Spouse**" as defined under the FMLA. At the time at which these regulations are written, FMLA defines a "spouse" as: a husband or wife. For purposes of this definition, husband or wife refers to the other person with whom an individual entered into marriage as defined or recognized under state law for purposes of marriage in the State where the marriage was entered into or, in the case of a marriage entered into outside of any State, if the marriage is valid in the place where entered into and could have been entered into in at least one State. This definition includes an individual in a same-sex or common law marriage that either:

1.15.1 was entered into in a State that recognizes such marriages; or

1.15.2 If entered into outside of any State, is valid in the place where entered into and could have been entered into in at least one State.

2.0 <u>Eligibility for benefits; serious health condition; certification or documentation of leave.</u>

2.1 **Employer Eligibility.** All the employees of an employer will be eligible for coverage under this Chapter, if they achieve either 10 or 25 of employees (the "threshold number") during the previous 12 months. For purposes of determining the eligibility of an employer group, "employees" includes those who meet the requirements of a covered individual under Section 3701(3)a., the 12-month waiting period requirement, and (3)b., the 1250 hours requirement, of this title, or who are reasonably expected to do so. Employees who are covered by a Waiver are excluded from this count towards the 10 or 25 employee thresholds.

2.1.1 **Employers with Fewer than Ten Employees**. If the number of employees working for an employer is below ten employees for the entirety of the previous 12 months (the "lookback period"), that employer group shall not be subject to any of the provisions of this Chapter, unless they elect to "opt-in" to any of the lines of coverage provided under this Chapter as provided under the provisions of Section 3717 of the Act (see Rule 17.0).

2.1.2. **Employers with 10 to 24 employees.** Employer groups that have more than nine employees but few than 25 during the previous 12 months shall only be subject to the Parental Leave provisions of this chapter. This means that if once an employer group has more than nine employees, they are required to provide Parental Leave coverage for at least the next 12 months. If more than 12 consecutive months pass and the employer group continues to stay below ten employees, the group will no longer be required to provide Parental Leave coverage. If they should thereafter rise to ten or more (but fewer than 25) employees, they will once again be required to provide Parental Leave coverage for at least the next 12 months. At any time while the employer group is between 10 and 24 employees, the employer may select to voluntarily "opt-in" to any of the lines of coverage per the provisions of Section 3717 of the Act (see Rule 17.0).

2.1.3 **Employers with More than 24 Employees**. An employer group with 25 or more employees during the previous 12 months shall be subject to all the Parental, Family Caregiving,

and Medical Leave provisions of this Chapter. If the group should fall under 25 employees, the group will still be required to provide all lines of coverage until the group remains below the 25-employee threshold for 12 consecutive months. On the 13th consecutive month, if the group is still below the threshold, they will no longer be required to offer Medical Leave, Family Caregiver Leave, or Qualified Exigency Leave. However, if the group should ever rise back up above 24 employees, the employer will once again be required to provide all lines of coverage for at least the next 12 months.

2.1.4 **Employee Notice**. Whenever an employee gains or loses any coverage provided under this Chapter due to a change in the number of employees in the employer group, the employees must be provided notice per the requirements of Rule 10.0 below.

2.1.5 **Continuation of Waivers.** If an employee and employer sign a Waiver such that the employee acknowledges that the terms of their employment does not anticipate them meeting the requirements for coverage, the Waiver survives through the employer group rising above or below any employee count threshold. Therefore, if an employee has co-signed a Waiver to decline coverage, they will not need to sign a new Waiver in the event that the employer group should fall, for instance, below nine employees for more than 12 months, then rises back above nine employees at some point thereafter.

2.2 **Certification**. Regarding certification for eligibility of benefits as stated in 19 Del. C. §3702(c)(3)a., the phrase "reason to doubt the validity of a certification" means the employer or private plan has credible, objective evidence that would reasonably support the employer or private plan to have a belief to suspect, question or not trust the legitimacy or soundness of a certification submitted by a covered individual.

2.3 **Health Care Provider Opinions**. Subsection 3702(c)(3) sets forth the process and requirements for obtaining first, second or third medical opinions from a Health Care Provider or Providers when a covered individual applies for benefits. A First Medical Opinion is provided at the Employee's expense. A Second Medical Opinion is provided by the Employer. A third opinion from a Health Care Provider is final and binding on the employer or private plan and covered individual.

2.4 **Recertification Standards**. Subsection 3702(c)(4) states that the standards to determine a reasonable basis for recertification may be governed by a collective bargaining agreement as described in that subsection. If no collective bargaining agreement or provision in such an agreement exists, the standard to determine a reasonable basis for recertification is based on a sworn affidavit of a direct witness to an event that brings the seriousness of the health issue into doubt. Only one recertification process can be requested or required every 30 days.

2.5 **Payment of Recertification**. Employer or an approved private plan is responsible for payment of recertification. Should any amount for recertification not be covered by a covered individual's health insurance, an employer or private plan is responsible for payment. As with all aspects of plan administration, the recertification process is subject to audits by the Department. If the Department determines that the employer routinely requires employees on approved Leave to undergo the recertification process such that it becomes a pattern of behavior, especially if the majority of those recertification processes reconfirms the justification for the employee's Leave, the employer may be subject to either the Job Protections provisions of this Act found in Section 3707 or the Retaliation provisions found in Section 3708.

2.6 **Documentation or Self-Certification**. Subsection 3702(d) states that a request for leave based on a serious health condition of a family member must be supported by documentation demonstrating the nature and extent of the relationship. Such documentation may include self-certification by the applicant on a form that the Department shall provide, as the Department may determine.

2.7 **Penalty**. If and in the event a false claim is made that the individual is not really the parent or child, the individual shall be disqualified of benefits for 3 years and the Department may seek repayment of any benefits improperly paid from the Fund and an additional penalty of up to 50% of overpayment and a penalty as permitted by Section 3719 of the Act.

3.0 <u>Duration of benefits.</u>

3.1 **Maximum allowable benefit period.** Eligible employees can only take a maximum of 12 weeks of Paid Family Medical Leave in any consecutive 12-month period. If an employee should elect to return to work earlier than the date provided for in their approved Leave schedule, their benefit payments shall be halted at the end of the every-other-week claims payment period in which they returned.

3.1.1 Parental Leave. The maximum duration of an approved Parental Leave is 12 weeks in any consecutive 12-month period.

3.1.1.1 Section 3703(f) of the Act provides employers with 10 to 24 employees with the option to reduce the Parental Leave maximum benefit duration from 12 weeks to 6 weeks for the for claims submitted prior to January 1, 2031 (the first five years after the start of benefits on January 1, 2026). In order to qualify for this option to reduce the maximum benefit duration, employers must notify the Department of their intention to do so by the January 1, 2024 deadline that also applies for requests to Opt-Out of the public plan and/or to grandfather employer's PTO benefit plans that existed before the 7/1/22 effective date of the Act. To take advantage of this option (to reduce the benefit duration for Parental Leave from 12 weeks to 6 weeks), the employer must notify the Department via the Division's online portal prior to the January 1, 2024 DEADLINE. If at any time before January 1, 2031, employers who have availed themselves of this reconsider their decision and decide to offer the full 12 week benefit duration for Parental Leave claims, the employer may do so by notifying the Division. If the Division receives a complaint that the changes were discriminatory or done in a discriminatory manner, the Department shall investigate the claims as it would any other claim of discrimination.

3.1.2 Family caregiving leave. in the unfortunate event that, while the employee is out on approved family caregiving leave to care for a particular individual and that person should pass away during the period of approved leave, the justifying reason for that leave has therefore ended. however, the department shall continue paying the benefit until the earlier of either seven days after the death of the individual or the previously approved end date for the leave.

3.1.2 **Family and Medical Leave Look-back period**. Subsection 3703(a)(2) states the maximum aggregate number of weeks during which benefits are payable for Family Caregiver Leave and Medical Leave is 6 weeks in any 24-month period. For all new claim applications, a look-back period will be required. The Department determines the look-back period is the 24-month period that ends on the first day of requested leave.

3.2 **Parent or Multiple Family Members**. Subsection 3703(b) states that the Department may determine to limit aggregate family caregiving leave requested when both employees work for the same employer the same qualifying event. The Department hereby determines those limits are that both employees may take the full amount of leave that they are allowed, but they may not take that leave concurrently.

3.3 **Receipt of a Completed Application**. An Employer has 5 business days of receipt of a completed application that includes documentation necessary to review the claim and to approve or deny an application for benefits. The date of an Employer's receipt of the completed application is not counted. The 5 business day time period does not begin until an Employer is in receipt of all necessary documentation, including the required documentation from the relevant healthcare provider.

3.3.1 If a claim is denied, an Employer shall notify the covered individual through the Department's online electronic system and provide the reason(s) for denial and submit copies of all documents relating to the claims application.

3.3.2 If a claim is approved, an Employer must notify and provide all supporting documentation to the Department through its online electronic system within 3 business days of a claim being approved under Chapter 37.

4.0 <u>Amount of benefits</u>.

4.1 **Standard Benefit Calculation.** Weekly benefit payments shall be calculated on the following basis:

- **Average Weekly Wage.** This is the "starting point" for the calculation. Take the average gross (before any deductions for taxes, premiums, or any other cause) weekly wages for the 52 weeks prior to the submission of the Claims Application.
- **Benefit Percentage, Minimum and Maximum.** Multiply the Average Weekly Wage by the Benefit Percentage, which, at the time of this writing, is 0.8. If the result is below $100, then the Weekly Benefit for that individual will be the average of the employee's weekly wages, even if the result is over $100. If the result is above $900, the Weekly Benefit amount shall be $900.

4.1.1 **Inflation Indexing the Maximum Benefit Amount.** Beginning on January 1, 2028, the Maximum Weekly Benefit amount will be increased in line with the inflation rate of the prior year.

In December of 2027 (for the 2028 calendar year) and every December thereafter, the Department will issue the Maximum Benefit Amount that shall be used for the applicable calendar year. The Act specifies that the inflation measure to be used in the Department's calculation will be the Consumer Price Index for all Urban Consumers, Philadelphia-Camden-Wilmington Metropolitan area, published by the Bureau of Labor Statistics of the United States Department of Labor. The Maximum Benefit for each calendar year shall be rounded to the nearest $5.00 increment.

4.1.2 **Preservation of the Fund Balance.** At the Secretary's discretion, in accordance with the provisions of Section 3705(c)(4) of the Act, the Benefit Percentage may be reduced to a level sufficient to maintain the solvency of the Fund on the effective date specified by the Secretary. The reduced Benefit Percentage will then stay in effect for at least the next 12 months. This will only be done to protect the integrity of the Fund. Notice by the Department will be provided before any such change in the Benefit Percentage prior to the effective date of the change.

4.2 The Department has determined that benefits be calculated for covered individuals with more than 1 source of wages and when 12 months of wages preceding the submission of application for benefits are not available to the Department, as follows:

4.2.1 If an Employee is working multiple jobs at the time of the qualifying event, each Employer must review the Employee's claims application based on the information about that particular job.

4.2.2 The applicable private or public plans will pay an approved claim as a separate claim.

4.2.3 If the State is the payer on multiple claims, it may combine the benefit payments into a single, bi-weekly payment, instead of multiple checks per payment cycle.

4.3 FICA Limits. … [provide a link to the appropriate section of federal law and restate the relevant portions of the law at the time that these regulations were written]

4.4 Delaware Wages. As the State of Delaware has no jurisdiction over wages earned outside of its boundaries and certainly has no authority to tax wages earned outside of the State, Paid Family Medical Leave insurance program benefits will be calculated only on the basis of wages earned within the State of Delaware.

5.0 <u>Contributions</u>.

5.1 In the course of regulating the payment of contribution under Subsection 3705(a), the Department requires that contributions be paid retrospectively at least quarterly, or more frequently if and as the Department regulates, based on the relevant information recorded during the period of coverage. Payroll taxes will be earned on wages paid on or after January 1, 2025. Those taxes shall be submitted to the Department on a quarterly basis, with the first payment to be received by the Department by April 1, 2025, and on the first day of each quarter, thereafter. At its discretion, the Department may provide up to a seven-day Grace Period during which Contributions can be submitted after the due date without late fees and/or penalties.

5.2 In remitting contributions to the Fund, an Employer or authorized intermediary acting on the employer's behalf shall provide contributions in any of the following forms and manners: for each employee, the employer shall provide their name and unique identifying information (DOB, SSN, etc.) and their previous quarter's weekly wages and hours worked, with each week's data broken out separately by the particular week, by in-state versus out-of-state hours and wages, and listed separately for each employee. The determination of whether an employee's particular hours or wages were earned in Delaware or outside of Delaware shall be determined according to whether the income that arose from those hours and/or wages was withheld from the employee's paycheck as in-state or out-of-state by the Delaware Department of Finance's rules or regulations.

5.2.1 Form of the Contribution: Quarterly and in a lump sum that combines the Employee and Employer shares for each of the 13 weeks in each quarter, accompanied by the information specified in 5.3.

5.2.2 An Employer must select its Employer/Employee Contribution split, if it differs from the Act's default of 50/50. Employers are free to contribute more than 50% of the total Contribution, but not less than 50/50. If an Employer decides to contribute a variation off of 50/50, the employer must properly notice the employer's variation to all affected employees and filed with the Department through its online portal system.

5.2.2.1 Any change in an Employee/Employer Contribution Split, either increase or decrease, shall be made only on the first day of the calendar year;

5.2.2.2 Employers may have different Employee/Employer Contributions Splits for different classes of employees, for example only management vs. hourly workers as long as:

5.2.2.2.1 the split applies equally to all that Employee Classes' lines of coverage; and

5.2.2.2.1 the Employee Classes are defined without reference to protected classes.

5.2.2.3 Any increase or decrease in the Employee/Employer Contribution Split must be properly noticed to all employees with an employer.

5.2.2.3 All rules regarding Employee/Employer Contribution Splits shall also apply to voluntary plans where an Employer opts into Paid Family Medical Leave coverage, including but not limited to designation that such voluntary plans are premiums.

5.3. Manner of Contribution: Funds and information must be submitted in electronic form, cash and checks will not be accepted. The Department may elect to allow employers to submit their Contributions by credit card, with an additional fee set by the Department for the convenience. In addition to monies, all employers shall be required to provide the following information, itemized by employee and tracked/reported on a calendar week basis:

5.3.1 Employer name and EIN or Individual Tax Identification Number (for Sole Proprietorships);

5.3.2 Employee name & unique identifier (Social Security, Permanent Resident Card, or Visa Foil number);

5.3.3 Weekly Hours (broken into Delaware vs. non-Delaware hours, if appropriate);

5.3.4 Weekly Wages (broken into Delaware vs. non-Delaware wages, if appropriate).

Note: The Act requires that Contributions and benefits be calculated according to the employee's FICA wages. The employer is required to perform the necessary calculations. The Division will perform these calculations on the data provided Quarterly by the employer & recorded / tracked by the Department.

Note: If the Employer's system (or their payroll servicing company's system) does not have this information available at a weekly level, but rather only on the basis of their payroll

period, then the Department will accept the above information based on an estimated weekly basis. For instance, for firms that send out their paychecks once every other week, the Department will accept the payroll period information divided by two (so that both weeks have the same numbers for all four datapoints). For monthly paychecks, the Department will accept estimated weekly information based on dividing the monthly wages and hours by the number of days in the pay period, then multiplying it by seven to arrive at an estimated weekly number for hours and wages (or by some other formula, as appropriate).

5.4 The combination rates for medical leave benefits for each 2025 and 2026, and 2027 and each calendar year after shall be tracked separately by the Department.

5.5 If and when there is a new rate, the new rate will be changed by modification to these regulations. Until then the rates are in effect for 12 months and automatically renew at the same rates as stated in the Act.

5.6 Per Section 3705(a), employers can only deduct Contributions from their employees' paychecks at the time that the Contribution was earned. This means that if the employer makes an error which would otherwise call for additional "back Contributions" to be collected from the employee, once the paycheck that would have been affected by the error has been issued, the employer cannot require the employee to pay their "share" of the employer's error. The employer has only one "bite at the apple" when it comes to making a payroll deduction for the employee's Contribution.

5.7 For purposes of Subsection 3705(h), the Department determines that an unpaid contribution as of the date it is due and payable required by the Department, shall accrue interest at a rate of 1.5% per month regardless of the total amount owed, from and after the due date until payment plus the accrued interest is received by the Fund.

5.8 Unless otherwise provided by the Act, the Department has the discretion to require or not require an approved private plan to remit contributions for medical leave benefits as required under Subsection 3705(b)(1).

5.9 Unless otherwise provided by the Act, the Department has the discretion to require or not require an approved private plan to remit contributions for family caregiving leave benefits as required under Subsection 3705(b)(2).

5.10 Unless otherwise provided by the Act, the Department has the discretion to require or not require an approved private plan to remit contributions for parental leave benefits as required under Subsection 3705(b)(3).

5.11 **Opting to file a waiver**. If both the Employer and the Employee agree that the employee was not hired with the mutually agreed upon expectation that the employee is intended to work on either a permanent basis and/or for at least 25 hours per week, such that they do not reasonably expect to be covered by this plan, then they can apply to waive coverage. To do so, they both must sign the Waiver of Coverage form provided by the Department and return it to the Department via the Department's online electronic system. The Waiver will be accepted by the Department unless the Department has a substantial and verifiable reason compelling them to not accept the Waiver, such as reasonable proof that the Employee is permanent or will be expected to work over 25 hours per week.

5.12 For purposes of Subsection 3705(k)(1), an Employer's notice to an Employee that their work schedule or length of employment, on a (permanent or temporary basis), does not meet the requirements for eligibility for family and medical leave benefits, must be provided in writing within the most recent quarter. In its discretion, the Department may waive coverages and the employee's portion of the tax for prior quarters, if the failure to provide the Waiver on a timely basis was not submitted due to clerical error. Waivers will be effective in the Quarter they are received. The employer's contribution shall not be waived for prior quarters.

5.13 **Waiver**. Should a waiver not be submitted to the Department, be unsigned, contain a clerical error or otherwise, the Department may accept a sworn statement from the Employer or Employee, as appropriate, as support for a missed deadline, missed payment, or other clerical error.

5.14 **Revocation of Improper Waivers.** Coverage under this Chapter is not optional. Waivers cannot be used to "decline coverage" for employees who would otherwise be eligible for coverage and who should not have any reasonable expectation that they should not be covered due to either the term of their employment or the number of hours that they work. Employers are required to provide accurate Quarterly information on all employees, including those employees who are on Waivers. If those records show that the employee has worked for more than 12 months for their employer group and that they have satisfied the 1,250 hours of service requirement during the

preceding 12 months, the Waiver will be revoked by the Department, which means that the employer will be responsible for the required payroll Contribution and the employee will become eligible for benefits beginning at the moment of the revocation of their Waiver.

5.15 Fines for Improper Waivers. If the Department determines that the employer and/or the employee signed the Waiver in a willfully false manner or if the employee worked substantially more than the minimum 1,250 hours in the previous 12 months (for example only, 25% more than the minimum number of hours), the employer shall be fined up to $1,000 for each instance and the employee shall be required to pay an amount equal to what they ought to have paid in payroll deductions.

5.16 Revocation of waiver. After an Employer submits to the Department, a form revoking a waiver as required by Subsection 3705(k), deductions from wages may not begin until a waiver is revoked. Upon submitting such a Repeal of Waiver Status form, the employee will thereafter be subject to the payroll tax and will begin their 12-month Waiting Period to submit claims applications.

5.17 **Form of waiver**. The Department has adopted a form for each a waiver and a revocation of waiver, as required under Subsections 3705(k)(1) and 3705(k)(2), which shall be available on the Department's website.

6.0 Reduced leave schedule.

For purposes of Subsection 3706(a), family and medical leave benefits for intermittent or reduced leave schedules must first be determined by Employer and if approved, then prorated by Employer. The requirements to approve an application for benefits under a reduced leave schedule are the same as exist for Leave periods of longer durations.

6.1 Minimum Duration of a Leave on Reduced Schedule. If an employee requests leave on a reduced schedule, the shortest leave that can be approved will be one full work day. Reduced leave will not be allowed in increments less than a full day.

6.2 Department's Responsibilities. The Department shall provide employers and employees with online tools, exportable reports, and forms to submit applications for Leave, both those Leaves on Reduced Schedule or otherwise, and to track the amount of Leave taken and still available to be taken under the rules of the Paid Family Medical Leave insurance program, both in increments of full days.

7.0 Leave and employment protection.

7.1 For removal of any doubt and for purposes of subsection 3707(b), an Employee or Covered Individual shall continue to be provided with and receive their medical coverage that they would have had if they had not taken leave. To continue to receive their medical coverage, the Employee must continue to pay their share of the medical premium or their Contribution.

Note: The Department will not withhold these amounts from the claimant's benefit payments. The employee is entirely responsible for paying their share of their medical premium as applicable.

7.2 At no time will the Department be responsible for sending an employee's share of their medical premium to an Employer for Employer's payment to the insurer.

7.3 For purposes of Subsection 3707(f), the phrase "date of the last event constituting the alleged violation for which the action is brought" or "willful violation" means [refer to definition in FMLA regulations].

8.0 Retaliatory personnel actions prohibited.

[CC: refer to the FMLA rules about this (unlawful to interfere with, restrain, ….).

CC: follow FMLA here (3708(e)).]

9.0 Coordination of benefits.

9.1 For purposes of Section 3709, the phrase "or otherwise coordinated" means claims which can be justifiably made under this Paid Family Medical Leave insurance program and other income-replacement plans for which the employee may qualify, including Workers' Compensation.

9.2 For purposes of Subsection 3709(a)(2) and if an Employer requires that payment made under the Act be made concurrently or otherwise coordinated, or leave allowed under terms of disability or family care leave under a collective bargaining agreement or Employer policy, an Employer shall give Employees written notice of Employer's requirements which shall include, at a minimum, the following:

9.2.1 Form for Claims Application: must include: [In Process], plus any additional requirements set forth in the Claims Application form that the Department shall create.

9.2.2 Claims paid under this Chapter that are eligible to be coordinated with other income-replacement or Paid Time Off plans shall be paid out on the following schedule, with the employee being required to submit information about any possible coordinating claim:

9.2.2.1 **Mandatory Benefits Under State or Federal Law.** When coordinating benefits with plans that are required under federal or state law, such as Workers Compensation, Paid Family Medical Leave insurance claims will be the primary payer. The Department will pay the full benefit as per the terms of this Chapter. The mandatory benefit program that pays out their claim second (or third, etc.) shall be entrusted to limit the combined benefit payments so that the total combined payments do not exceed the employee's average weekly earnings prior to the qualifying event.

9.2.2.2 **Voluntary Insurance Plan or Employer-Paid Programs.** When a qualifying event that might trigger a Paid Family Medical Leave insurance claim arising from this Chapter, might also be a qualifying event according to the provisions of a voluntary insurance plan or other type of employer-provided Paid Time Off (vacation days, sick days, floating holidays, personal days, and the like; but excluding any "donated" leave programs in which additional Leave is not automatically granted to employees) or income-replacement program (such as, Short Term Disability insurance or the Personal Injury Protection provisions of an Automobile Insurance policy) in which the employee is enrolled, this program will be paid second. This provision also applies to PFML Leave that is taken on a Reduced or Incremental Schedule. Employees are required to use up to 75% (rounded to the next whole number of days) of their remaining applicable employer-provided Paid Time Off for that benefit period before they can access benefits under this Chapter.

For example only: in a situation where an employee is eligible for seven sick days, three floating-holidays, and ten days of paid vacation (for a total of 20 paid days off) in a given calendar year, and they have already used six of those days (meaning that they still have 14 days off remaining) when they experience a qualifying event under this PFML insurance program. In this situation, the

employee would have to take 11 of their remaining 14 days (14 x .75 = 10.5 days rounded up to 11) before being able to access PFML benefits. However, after they return to work from Leave, they will still have three remaining paid days off.

9.3 For purposes of Subsection 3709(a)(4), the term "wages" provided here has the same meaning as defined in the Act, which follows the regulations defining the Federal Insurance Contributions Act ("FICA") wages.

10. Notice.

[DOL should duplicate the language that the DOI uses in their regulations.]

10.1 Upon determining an application and if approved, the Employer shall I provide to the claimant written notice of its determination and approved amount of payment in electronic format through electronic mail systems with a copy to the Department via the Division's online Portal system. If mailing by U.S. Mail, overnight mail, or certified mail is required by law, then notice shall be provided in electronic format and manner as stated in Section 10 and also by mail in the manner required.

10.2 The written notice referred to above shall be mailed to the claimant by regular mail thorough the United States Postal Service at the claimant's last known address and through electronic mail systems to their last known personal and employee email address, and shall include at least the following information:

10.2.1 The amount of the payment;

10.2.2 The party or parties to whom the instrument is made payable;

10.2.3 The party to whom the instrument was forwarded; and

10.2.4 The address of the party to whom the instrument was forwarded.

10.3 Nothing in this Rule No. 10.0 above shall create a cause of action for any person or entity, other than the Delaware Insurance Commissioner or the Department, against an Employer based upon a failure to serve such notice, or defective service of such notice. Nothing in this section shall establish a defense for any party to any cause of action based upon a failure by the Employer to serve such notice, or by the defective service of such notice.

10.4 For purposes of Subsection 3710(c), the phrase “a conspicuous place accessible to employees” includes but is not limited to the following: [duplicate the requirements for the other posters that DOI/DOL require]

10.5 In addition to the requirements set forth in Section 3710 of the Act, the Department adopts requirements concerning the means by which employers shall provide notice of the Act:

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11.0 Employee Claims, Employer Adjudication, and Departmental Review.

11.1 **Employee Claims Process.** If an employee wishes to make a claim, they must use the Claims Application form provided on the Division’s online Portal. The employee must complete and submit the form on the online system. The Division will not accept physical copies and/or scans of physical copies that have been completed by hand, manual typewriters, or similar devices. The online Portal will distribute the Claims Application form to both the employer and Division.

11.1.1 **Designated Employee Assistant in Case of Employee Incapacitation or Inability to Manage Claim**. If an employee is unable to complete the necessary paperwork (for example, due to the serious illness that is the qualifying event under the Medical Leave provisions described in Section 3702(a)(3) of the Act) or inability to access or operate the online system, a family member or other individual who does not benefit in any way, directly or indirectly, from the decisions or actions they make or would make in this role, may, through a signed, sworn Assistant Designation form created by the Department, be appointed to assist the employee. While acting as the designated Assistant, the individual acts as a trustee for the employee; they shall not benefit from the decisions or actions they make, directly or indirectly, as part of that role at any time. If the designated Assistant benefits from any decision or action made while serving as the designated Assistant, they will be subject to any applicable civil or criminal penalties. The Department, the employee, or their estate shall have the authority to pursue any claims arising from the Assistant’s actions or decisions, through any appropriate legal means. The employee may revoke their designation of an Assistant at any time. Only one Assistant can be appointed at any one time, with the individual named in the chronologically applicable filing being recognized for that specific time

period. The online Portal will distribute the Assistant Designation form and, if applicable, the Revocation of Assistant Status form to both the employer and Division.

11.2 **Employer's Responsibilities, Adjudication, Protections**. Employers shall adjudicate the employee's Claims Application form to the best of their ability, per the "reasonable person" standard. As required in the Act, the employer shall be expected to make a determination as to whether the claims should be paid, the amount of weekly benefit due to the employee, and the length of time the benefit should be paid out, according to the terms and provisions of the Act and based on the information provided by the employee and certified by the appropriate healthcare provider, in a manner and to the extent that a reasonable person would be expected to do so. The employer shall not be required to make any substantive claims-related decision based on information not in their possession, but they must make a good faith effort to gather all the required information from either the employee, the designated Assistant, or the appropriate healthcare provider to make an informed and reasonable decision on the eligibility and payment or ineligibility of the request.

After all necessary documentation has been received by the employer via the Department's online Portal system, the employer shall have five business days to adjudicate the claim. The length of the approved Leave shall be based primarily on the recommendation of the appropriate healthcare provider, as supported by Disability industry standards and best practices in this area. After the claims determination is made, the employer will then have three business days to communicate their decision via the online Portal system to the employee (and/or their designated Assistant) and the Department.

11.3 **Department's Responsibility to Pay Approved Benefit.** The Act provides that the Department, through the Division created by the Department to administer the Paid Family Medical Leave Insurance Program, shall be required to make the first payment of benefits to a covered individual within 30 days after the employer has notified the Department of the approved claim, with subsequent payments being required to be made every 2 weeks thereafter until the approved length of the employee's Leave expires. New requests for (or requested changes to) benefits payments shall be due two days before the day on which the Division pays out biweekly claim

payments, to allow for claims to be reconciled. After approval, a new benefit payment or an adjustment to a previously approved claim will be released by the Division between two and sixteen days after the approval or adjustment is granted by the Employer.

11.4 **Employee's Right to Request a Claims Review by the Department**. If an Employer denies a claim for paid family and medical leave benefits, the employee or their designated Assistant may request, within 60 days of issuance of Employer's decision, that the Department review the claim. In other words, this is within sixty days of the end of the three day period that the employer has to communicate the decision that they made within ten days of gathering the necessary documentation to adjudicate the claim; which is to say, 63 days from receiving all the necessary information but an unspecified length of time from when the date the Claims Application form was originally submitted as there is no limit to the time it can take to gather the required documentation. This request for the Department to review the claim must be made via a Claims Review Request form that shall be created by the Division and made available to the public on the Department's online Portal. Neither the employer nor the Department shall be required to respond to either a handwritten (or manually typed) form submitted by any means other than the online Portal or to a handwritten (or manually typed) form that has been scanned and then submitted through the Department's online Portal system, as neither of those methods are acceptable and will update the Department's electronic claims database / records system. After the Claims Review Request form has been completed and properly transmitted to the Department, the Division shall undertake a review of the employer's claims adjudication decision-making process.

11.5 **Department Initial Claims Review Determination**. The Department shall review the claim and issue an initial determination in writing to the individual within ten (10) business days of receipt of the individual's request, in accordance with Rule No. 18.

If, after submissions from the parties, the Department initially determines an employer violated 1 or more provisions of Chapter 37, or a covered individual received overpayment or violated Section 3712 of Title 19, the Department shall notify the appropriate party in writing, both by regular mail and by electronic means, within five (5) days of its initial determination. The notice shall provide, at a minimum:

the date of the notice, amounts owed, civil penalties under Section 3719 if a violation is determined, and an opportunity to appeal the Department's initial determination to the Board.

11.6 **Family and Medical Leave Insurance Appeal Board**.

The Board hereby adopts the following regulations to implement Section 3711 of the Act:

11.6.1 If a covered individual or employer appeals to the Board within 15 days from the date of notice of the Department's initial determination, the Board shall provide notice within 5 days that a date has been set for an Appeal Hearing subject to the Board's schedule.

[few foundational examples provided in brackets]

[These rules govern practice and procedure in all matters before the Board and shall be liberally construed to secure a just, economical, and reasonably expeditious determination of the issues presented in accordance with the Board's statutory responsibilities.]

[The Board may for good cause, either upon application or upon its own motion, waive any of these rules of practice and procedure provided there is unanimous approval by the full Board.]

[All communications or documents to the Board shall be filed electronically as directed by the Department.]

[A claimant, Employer and the Department shall provide the Board with a complete copy of their records and files regarding the claimant's application. The Board's review shall be based upon the records submitted.]

[All documents required to be filed with the Board shall be electronically filed with the Department within such time limits, if any, as may be fixed by law, rule, or order of the Board. The Board Administrator shall not accept any electronic filing until the fee, if any, required by law or rule shall have been paid.]

Each communication addressed to the Board and on each document electronically filed with the Board, shall automatically bear the time and date of receipt by the Board.

After docketing of any matter by the Board, all papers of whatever character offered for filing in the docket by any party, shall show the title of the proceeding, a docket number if any, and the name of the person submitting the documents. .

[The Board's date and time stamp shall not be affixed to any document which, in the exclusive and final determination of the Board Administrator or his or her designee, is not sufficiently legible as received.]

[Each person submitting a claim or other document with the Board in any proceeding shall, not later than the time of filing, serve by electronic means a copy of such document on each party, or other person required to be served by rule, order, or law. An employee shall in all events serve his or her employer with a copy of any filing with the Board and the employer shall serve any employee or his or her counsel.]

No member or employee of the Board who will participate in any way in the rendering of a decision on a matter pending before the Board shall, directly or indirectly, discuss or communicate, concerning such matter with any party, except upon notice to and opportunity for all parties to participate. This rule does

not apply to communications required for the disposition of *ex parte* matters authorized by law, or to communications, not otherwise prohibited, by and among the members of the Board, Board staff, and Board legal counsel.

[In computing any period of time prescribed or allowed by any rule, order, or notice of the Board, the day of the act, event, or default after which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it falls on a Saturday, Sunday, or a day made a legal holiday by the laws of this State or of the United States, in which event, the period runs until the end of the next day which is not a Saturday, Sunday, or legal holiday. When the period of time prescribed is less than ten (10) days, intermediate Saturdays, Sundays, and legal holidays shall be excluded in the computation.]

[All appeals filed with the Board, shall be on the form provided by the Department and shall be signed by the employee or and shall include at least the following:

A specific identification of the act or omission complained of and the date or dates of occurrence or non-occurrence;

The identification of the Act or Rules alleged to have been violated;

A summary of the argument and legal authorities to be presented;

Full name, mailing address, and telephone number of the claimant;

If applicable, a copy of the initial determination by the Department.]

[any limits or restrictions on hearings? – time limits, requests beforehand]

An employee in any Board proceeding may file and serve a motion at any time unless otherwise provided. A written motion shall contain a concise statement of the facts and law which support it and a specific request for relief. Any case dispositive motion, such as a motion to dismiss, should be filed and served as soon as possible prior to the start of the hearing. A written reply to a case dispositive motion may be filed. No motion may be filed with the Board without proof that a copy of the motion has been served on the non-moving party(ies).

The Board permit oral motions and oral or written responses to be made during a hearing.

At least five (5) business days before the hearing, the parties shall exchange their proposed exhibits and witness summaries with copies to the Department; all documents shall be submitted electronically, no files or documents will be accepted in physical form.

A verbatim record of the proceedings before the Board will be made and archived electronically.

[All testimony before the Board shall be taken under oath or affirmation. Evidence which is irrelevant, immaterial, or unduly repetitive may be excluded. Delaware's rules of evidence shall not apply for any documents submitted or testimony given.]

[The claimant will be afforded the opportunity to open the hearing with a brief opening statement. Following this statement or waiver thereof, the other party will be allowed to make a brief opening statement but only if the statements are germane to the matter at hand. Thereafter, the claimant shall present evidence in support of its position limited to the information directly relevant to the issues at hand. Following questions, if any, the other party will be allowed to present evidence which will be

subject to questions. The party having the burden of proof normally has the final opportunity to present evidence or statements.]

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12.0 Erroneous payments; disqualification for benefits.

[Rule No. 12.0 purposely left blank in interim]

13.0 Family and Medical Leave Insurance Program.

The Department shall establish and make available to employees? And employers? on the Department's online Portal system, reasonable procedures and forms for filing claims for benefits and other required or requested processes, and shall specify the supporting documentation necessary to support a claim for benefits, including any documentation required from a health care provider for proof of a serious health condition.

In order to provide an incentive to healthcare providers to encourage the timely completion and submission of the requested supporting documentation, the following schedule of payments shall be used:

Documentation is completed in full and submitted to the Department via the online Portal system within 30 calendar days of being sent by the Department:	$10 per claim
Documentation is completed in full and submitted to the Department via the online Portal system within 10 business days of being sent by the Department:	An additional $10 per claim

14.0 Federal and state income tax.

The Division shall withhold state and federal income tax from authorized benefit payments. The withholding shall be made at a single flat percentage, that will be applied to all benefits paid out during a calendar year. In December of each year and beginning in 2025, the withholding percent for the following year for federal income taxes shall be established based on the average federal effective income tax rate for the prior year, as calculated in accordance with the data series entitled "Average Federal Tax Rates, by Tax Source, Individual Income Taxes" published by the Congressional Budget Office's annual report entitled "The Distribution of Household Income," which was published in November 2022, for information gathered in 2019.

By the end of January, the Division shall send each claimant an accounting of the benefits amounts paid out and the federal and state taxes withheld during the previous calendar year. The accounting shall be presented and follow the rules of IRS form 1099G and shall be sent both by regular mail and in electronic form to the last known address of the claimant, with a record also sent to the federal IRS and the Delaware Department of Revenue by the format and means that those agencies require.

15.0 Family and Medical Leave Insurance Account Fund; establishment and investment.

For purposes of this Section 3715 and these regulations, the Department may use expenditures from the Fund to pay for the costs associated with administering the provisions of Chapter 37, Title 19. "Administrative costs" include but are not limited to: [refer to GASB standards]

The deposits into and withdrawals out of the Family and Medical Leave insurance account fund shall be tracked, accounted for, and verified on a calendar day basis.

The Office of the State Treasurer shall manage and invest the monies in the Fund per their standard policies. The Division shall follow Government Accounting Standards Board (GASB) rules in recording the transactions of the Division's account.

16.0 Private plans.

16.1 For purposes of Section 3716(a)(1), the Department of Insurance has agreed to administer the requirements under Section 3716(a)(1) to certify that insurance plans issued by carriers admitted to sell insurance in the State of Delaware have either met or exceeded the requirements for either some or all of the lines of coverage (including requiring that Family Caregiver insurance plans also provide Qualified Exigency Leave) as provided under the Act. The Department of Labor will provide additional approvals that Employers who "opt-out" (in whole or in part, as a hybrid plan) meet their obligations under Chapter 37 through a private plan, as set forth in the Act.

16.1.1 **Insured Private Plans**: per Section 3716(1), employer groups must notify the Department through its online portal of employer's decision to opt-out of the state's Public Plan by January 1, 2024, as required under the Act. The state's opt-out form(s) will be made available to the public by October 1, 2023 on the Department's online portal. By January 1, 2024, employers must indicate that they intend to purchase a DOI-certified PFML insurance plan, which may include coverage through an approved captive insurance plan approved by the Delaware Department of Insurance, for

one or all of the required lines of coverage. Before January 1, 2025 (the start of Contributions under the Act), employers must send the Department proof that they have acquired a private insurance plan to fulfill some or all of their obligations under the Act and provide a copy of the policy contract through the Department's online portal. Failure to obtain such coverage and/or to provide a copy of the insurance contract will mean that employer cannot opt-out and must, instead, comply with the provisions of the Act regarding the submission of Contributions to the Public Plan on January 1, 2025.

16.2 An Employer shall impose no additional conditions or restrictions on the use of covered leave beyond those explicitly authorized by Chapter 37 or regulations issued under that same chapter. Notwithstanding any other conditions or restrictions, the Department adds the following conditions or restrictions for private plans:

16.2.1 All correspondence and transfer of funds shall be transacted electronically.

16.2.2 Required Data. Each quarter, insurance carriers will be required to send the Division updated weekly enrollment, wages, and hours information for each employee covered under their plans. This information must be provided to the Division through the Division's online portal according to the technical specifications required at the time of submission.

16.3 The requirements for the private plan and internal administrative review process when a final determination is issued are subject to the appeal process consistent with Section 3711 of Title 19.

16.4 **Self-Insured Plans**: per Section 3716(2)(a), employer groups must notify the Department through its online portal of employer's decision to opt-out of the state's Public Plan by providing a private plan through a form of self-insurance by January 1, 2024, as required under the Act. The state's opt-out form(s) will be made available by October 1, 2023 on the Department's online portal.

Self-Insured Groups must have at least 100 covered employees in the plan at all times. Applicant groups with fewer than 100 eligible employees will have their applications declined. If any self-insured group falls below 100 employees at the time of their annual renewal (by December of each year), they will be decertified and will be required to join the Public Plan, triggering payment by the surety bond from the current calendar year. The Department may waive this requirement if the employer is able to demonstrate that it has the administrative capacity to adequately manage a self-insured plan.

Each quarter, all self-insured plans must send the Division updated weekly enrollment, wages, and hour information for all the employees covered under their plans. This information should be provided to the Division through the Division's online portal according to the technical specifications required at the time of the submission.

16.4.1 **Surety Bonds:** By January 1, 2024, employer groups that intend to provide the mandated coverage through a self-insured plan for one or all of the required lines of coverage must also provide the Department a copy of the surety bond required under the Act.

Employer shall purchase a new surety bond for each calendar year and send the Department a copy of the annual bond to the Department by each December 1st along with any changes to the plan's Schedule of Benefits and a report detailing the current number of eligible employees covered under employer's self-insured plan. If the plan no longer "meets or exceeds" the provisions of the Act or if there are less than 100 eligible employees covered under the plan, the self-insured plan will not be allowed to renew for the next calendar year.

Failure to obtain and provide a copy to the Department of a new annual surety bond by each January 1st or an unapproved plan design change or a drop below 100 eligible employees being covered by the self-insured plan shall result in the employer group being required to join the Public Plan on January 1st. It shall also result in surety bond from the prior year paying out its coverage amount (one year's premium equivalent) to the Fund, thereby alleviating the need for employees to satisfy the standard 12-month employee waiting period that they would otherwise need to satisfy before the payment of any claim under the Act.

The State of Delaware shall be the obligee of the surety bond with the employer group being the named principal. The amount of the surety bond shall be determined by a calculation to project the equivalent of one year's worth of Contributions to the Public Plan if that group had been in the Public Plan. This calculation must be determined by a qualified actuary (having met the American Academy of Actuaries' qualification standards) or licensed Certified Public Accountant (CPA), who must attest to the reliability of the calculation.

The contribution amount shall be based on the actual wages, adjusted for inflation by the Consumer Price Index for All Urban Consumers, Philadelphia-Camden-Wilmington Metropolitan area that is

published by the Bureau of Labor Statistics of the United States Department of Labor, earned by the employees in the 12-month period ending on October 31st prior to the December 1st due date of the delivery of the copy of the annual surety bond. Therefore, for a self-insured plan renewing for 2028, employer would calculate the actual wages earned by the employees (with no employee excluded from the calculation, as none have a signed Waiver) that were earned between 11/1/2026 – 10/31/2027, adjusting it for inflation, then applying any applicable FICA limits to the employee's wages, and then applying the Contribution rate. A copy of the surety bond based on that calculation must be provided to the Department by 12/1/2027. Failure to provide an annual copy of the surety bond supported by a signed statement by either a qualified actuary (having met the American Academy of Actuaries' qualification standards) or licensed Certified Public Accountant (CPA) will result in the employer group terminating their self-insured plan effective 12/31 and entering the Public Plan as of (in this example) January 1, 2028.

16.4.2 **Self-Insured Plan Design**: For any line of coverage that the employer provides under a self-insured plan, the terms and conditions of the plan must at least meet the requirements provided in the Act. Beginning with the opening of the Department's online portal system on October 1, 2023, the employer must provide a copy of the self-insured plan's schedule of benefits, terms, and conditions to the Department for its review and approval. The last day to submit this information is October 1, 2024 and the Department must either approve or decline the employer group's application for self-insurance by December 1, 2024, when the employer is also required to provide their surety bond. If the Department does not approve the group's application for self-insurance, the employer must instead comply with the requirements of the Act by joining the Public Plan.

The Department will accept a sworn self-certification/attestation listing specific, detailed components of the plan design that need to be at least met, signed by the employer as initial proof that the plan design meets or beats the Public Plan design. At its discretion, the Department will verify the attestation by comparing the submitted plan documents to the requirements of the Act. If, at any time, the Department finds that the employer's self-insured plan does not meet or exceed the requirements of the Act, the Department shall have the power to immediately decertify the employer's self-insured plan, triggering

the payment of the surety bond, and adding the employer group to the Public Plan with no lapse in coverage for the employers.

Any proposed changes to any of the provisions of? an approved self-insured plan must be approved by the Department in writing and must be equal or exceed the requirements of the public plan. Changes to the plan can only be made at the beginning of each calendar year, unless the Department approves a different effective date.

16.4.3 **Self-Insured Plan Claims Fund**: The Department reserves the right to audit the financials of any employer applying to administer a self-insured plan that it has the financial ability to pay all expected claims for that group. Employers with a self-insured private plan must have the financial ability to pay at least eight maximum dollar claims per 100 employees per year and each employer with a self-insured plan must prefund a claims account with at least half of that amount held in reserve to pay future claims.

16.4.3 **Audits and Claims Reviews of Self-Insured Plans**: Employees and their designees shall be able to avail themselves of the Claims Review process as set forth in Section 3711(a)(1) of the Act.

Per Section 3718 of the Act, the Department retains the right to audit any and all claims or enrollment decisions made by the employer in any self-insured plan. The employer must make available to the Department any requested documentation, file, or system regarding any issue in connection with an audit of the self-insured plan within 24 hours of the Department's written request.

Self-insured plans that are found, either through the Claims Review or Auditing process, to have an excessive number of mis-adjudicated claims, either due to error or arising from a purposeful attempt to deny claims for, among other things, punitive, discriminatory, and/or financial reasons will be referred by the Department to the Delaware Attorney General for, at the Department of Justice's discretion, civil and/or criminal prosecution.

16.5 **Grandfathering Plans**: per Section 3716(2)(e) of the Act, private Paid Time Off (PTO) benefit plans that employers had in place before July 1, 2022, the effective date of the Act, and that are deemed by the Department to be comparable to the state's public plan, will be allowed to continue as it had been administered at the time, until January 1, 2030, five years from the start of Contributions being

collected. Employer PTO benefit plans will qualify regardless of their risk transference provisions, including but not limited to any of the following arrangements: private insurance contracts through an admitted carrier including captives, self-insured plans regardless of whether they are backed by a surety bond, or "Employee Handbook plans", which continue paying an employee's wages in the same manner as it had been paying prior to the leave, while the employee is on a period of leave, that is defined only in through the terms of the contractual relationship between employer and the employee usually as described in an Employee's Handbook.

16.5.1 **Grandfathering Application**: In order to qualify for the five-year grandfathering period for existing plans, employers must submit an application form through the Department's online portal by the January 1, 2024 deadline described in Section 3716. If an employer does not submit an application by January 1, 2024 through the portal, the employer shall automatically be added to the state's Public Plan by the Department. If the employer's application is declined, the employer shall automatically be added to the state's Public Plan by the Department. If the employer's application is approved by the Department, the employer and their employees will not be subject to the Contribution provisions of the Act until January 1, 2030, after which time that employer's employees will not be allowed to submit a claims application under the Act until January 1, 2031.

16.5.2 **Definition of a Comparable Plan**: For an employer's PTO benefit plan to be considered to be in existence as of July 1, 2022, the employer must submit a sworn affidavit that the plan had been available to all of the employer's employees or a legitimate class of employees such as, "all Managers" or "all unionized employees" and properly noticed in writing, including a copy of the plan, via the Department's online portal. The employer's PTO benefit plan may qualify even if does not provide all four lines of coverage included in the state's Public Plan, as long as the plan provided or provides? comparable coverage on one or more of the lines of coverage.

Each application must include a copy of the employer's PTO benefit plan for consideration by the Department. All employer PTO benefit plans that offer benefits that equal or exceed the state's Public Plan in three specific components of the plan design will be approved as grandfathering. An employer's PTO benefit plan will be considered "comparable" if the plan's three main plan components (Benefit

Percent, Maximum Benefit, and Benefit Duration) are within 25% of the equivalent state plan components. For example:

16.5.2.1 Benefit Percent – The Act provides for 80% of the employee's wages, 25% less than 80% is 60%. So, if the employer's PTO benefit plan pays out at 60% or better of the employee's wages, it will be considered comparable for that component of the plan.

16.5.2.2 Maximum Benefit – the Act provides for a maximum weekly benefit of $900 & 25% less than $900 is $675. So, if the employer's PTO benefit plan caps off at $675 or more of the employee's weekly wages, then that criterion of the plan is considered comparable to the state's Public Plan.

16.5.2.3 Benefit Duration – for Parental Leave, the Public Plan allows up to 12 weeks of Leave. If an employer's PTO benefit plan allows 9 or more weeks of Parental Leave, then it will be considered comparable. For all other types of Leave, the Public Plan allows for 6 weeks of Leave. If the employer's PTO benefit plan allows for all employees to receive up to 4.5 weeks ,or 32 days, of Leave or more, then it will be considered comparable.

An employer's PTO benefit plan must be within 25% of all three of these plan components for the employer's Grandfathering Application to be accepted by the Department. Alternatively, an employer's existing PTO benefit plan will also be considered "comparable" to the Public Plan if the employer's PTO benefit plan provides for a maximum of *xx* days or more of combined Paid Time Off at full salary. If the application is not accepted, the employer group must enroll in the state's Public Plan.

In addition to the above, for an employers' existing Paternal Leave plan to be comparable to the Public Plan for the Paternal Leave line of coverage, an employer's PTO benefit plan must provide:

- coverage for birth, adoption, and fostering of a child; and
- it must be granted regardless of the parent's sex or gender or marital status.

For example, if the employers' plan is just a "Maternity Benefit", it will not qualify for grandfathering.

During the five year period during which the plan is Grandfathered, until December 31, 2029, the employer shall not alter any of the terms or conditions of the employer's PTO benefit plan as it existed as of July 1, 2022, unless such a change is approved in writing by the Department.

16.5.3 **Short Term Disability Plans**: employers with short term disability (STD) plans that meet the 25% test in subsection 16.5.2 above are eligible to be grandfathered. However, due to the number of such plans and the potential for them to adversely impact the solvency of the Fund, the Department will undertake an analysis of the impact of STD plan grandfathering on the future solvency of the Fund based upon the actual experience of the Medical Leave line of coverage in each of the initial years of the program. If the grandfathered STD plans are determined to be a threat to the solvency of the Fund, their grandfathered status will be revoked earlier than normally provided by the Act.

17.0 Small business opt-in.

17.1 **Voluntary**. For all Small business, the ability to opt-in to provide parental leave benefits, medical leave benefits, or family caregiving leave benefits, is a voluntary benefit plan. As such, the employer and employee payroll "Contributions" to fund these voluntary benefit plans are not considered taxes, but rather they are premiums. The Division and the Office of the State Treasurer need not create separate bank accounts to hold these premiums, but it should track these premiums separately from the taxes collected for the mandatory Paid Family Medical Leave insurance plans. By the end of every January, beginning in 2026, the Division shall report these premiums to the necessary individuals, entities, and agencies on the proper forms as issued by the federal Internal Revenue Service and the Delaware Department of Revenue.

17.2 **Notice to the Department**. For all opt-ins and opt-outs of any of the benefits, a small business must provide notice to the Department on the appropriate forms to be created by the Department and available on the Department's online Portal system. All forms and processes shall take place in or by electronic means as established by the Department. Notwithstanding any provision to the contrary, employers who opt-in or opt-out of the State's public plan will do so on an effective date at the beginning of each calendar year.

18.0 Powers of the Department.

18.1 **Forms**. The Department shall create forms, including a form for a complaint, that may be filed with the Department for a claim of non-compliance with Chapter 37. The forms can be located on the Department's website and at its locations of business. All forms shall be produced and be made

available on the Department's online Portal and website in both English and Spanish. The website itself shall be available in both languages, as well. If a third (or fourth, etc.) language achieves a level of common usage such that it is primarily spoken by 5% of the state's population (as established by the U.S. Census Bureau), that (those) languages shall be used in all forms and communications, in addition to English and Spanish. All written material (electronic or in physical form) released by the Division shall be formatted so that it can machine read for purposes of improved Accessibility for people with disabilities.

18.2 **Audit**. In addition to those powers stated in Section 3718, the Department may audit employers for compliance with Chapter 37, as the Department determined. The Department reserves the right to examine any adjudicated Claims Application, whether they have been approved or denied, on a random basis. Admitted private insurers with certified Paid Family Medical Leave coverage plans shall give the Division access to their records systems, along with the training and/or assistance necessary to understand the materials therein, such that the Division may audit claims adjudicated by those carriers. The records and systems of self-insured private plans shall likewise be made available to and intelligible by the Division for auditing purposes.

18.3 **Department Audit and Investigative Authority**. The Department may enter and inspect an employer's premises or place of business or employment. In so far as possible, the Department will attempt to arrange a mutually acceptable time for such inspections, providing at least 1 business days' notice to employer, excluding weekends or State holidays, where the notice is given before 12 noon.

18.3.1 All employers shall keep and preserve any or all books, registers, payrolls, and other records, including those required by Chapter 37, for at least five (5) calendar years. Items preserved or archived in electronic form (rather than in physical form) for five (5) years shall be considered to satisfy this requirement.

18.3.2 The Department may deem it necessary or appropriate to prescribe or approve forms, which may be used by an employer for statements, sworn statements, or other information the Department determines.

18.4 **Department Initial Determination**.

If, after submissions from the parties, the Department initially determines an employer violated 1 or more provisions of Chapter 37, or a covered individual received overpayment or violated Section 3712 of Title 19, the Department shall notify the appropriate party in writing within five (5) days of its initial determination. The notice shall provide, at a minimum: the date of the notice, amounts owed, civil penalties under Section 3719 if a violation is determined, and an opportunity to appeal the Department's initial determination to the Board.

18.5 **Appeal to the Board**. If a covered individual o appeals to the Board within 15 days from the date of notice of the Department's initial determination, the Board shall provide notice within 5 days to provide notice that a date has been set for an Appeal Hearing subject to the Board's schedule.

18.6 Notwithstanding any other provision in the Act or these Rules, the Department of Insurance shall have primary jurisdiction and the Department shall have authority to pursue any issues in its jurisdiction that the Department of Insurance declines to pursue.

19.0 Penalties.

19.1 **Penalty.** Where the Department deemed an employer in violation of Chapter 37 and subjected to a civil penalty, such penalty such be not less than $1,000 nor more than $5,000 for each violation. The Department has determined that "each violation" means each alleged action against each employee. For example only, a failure to pay the contributions for an employee who would have been eligible for five years is a total of 20 violations, specifically four missing quarterly reporting periods per year, over a five year period.

19.2 **Civil Penalty Claim**. _____

20.0 Regulations.

In accordance with Section 3720 of the Act, the Regulations adopted herein take effect 10 days after their final publication.

21.0 Reports.

[Subsection 21.0 purposely left blank in interim]

22.0 Public education.

When making outreach information available, the Department may determine those languages, other than English and Spanish, that are spoken by more than 5% of the state's population at the time. Under

the terms of Section 3722(b), the Department may use a portion of the monies collected in the Fund to pay for a public education plan. The Department may also use other funds, once properly authorized by the Secretary of Labor or other appropriate officials, from the State of Delaware or other sources to pay for a public education program.

23.0 Sharing technology.

[Subsection 23.0 purposely left blank in interim]

24.0 Departmental Report.

[Subsection 24.0 purposely left blank in interim]

Effective:

DE Reg.